**Department of Veterans Affairs** **VHA DIRECTIVE 2003-054**
**Veterans Health Administration**
**Washington, DC 20420** **September 29, 2003**

# RECORDING OBSERVATION PATIENTS

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides policy for the definition and recording of observation patients.

## 2. BACKGROUND

a. In many instances, placing patients in the most appropriate clinical setting requires "observing" a patient for an extended period of time without admitting them as an inpatient. Observation units are considered to be outpatient or ambulatory services. The goal of observation is to resolve symptoms or clarify a patient's diagnosis.

b. Patch DG*5.3*176 was originally released to implement this Directive. Appropriate Integrated Billing (IB) patches have been released and will be released in the future.

c. **Definitions**

(1) **Observation Patient.** An observation patient is one who presents with a medical condition showing a significant degree of instability or disability, and who needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. ***NOTE:*** *These types of patients need to be evaluated against standard inpatient criteria.* An observation patient can occupy a special bed set aside for this purpose or may occupy a bed in any unit of a hospital, i.e., urgent care medical unit. These beds are not designed to be a holding area for Emergency Rooms. The length-of-stay in observation beds will not exceed 23 hours. ***NOTE:*** *Routine post-procedure recovery from ambulatory surgery is not observation. Examples: Recovery from a cardiac catheterization and release from the facility within 6 hours of the completion of the catheterization would not constitute post-surgical observation since the normal recovery time is 4 to 6 hours. A patient may report to the medical center for laser removal of cataracts. During the laser procedure, the patient may have a reaction to some of the medication and would be admitted to the appropriate bed section for evaluation of the reaction.*

(2) **Lodger.** A lodger is not an observation patient. By definition, a lodger does not receive health care services.

**3. POLICY:** It is VHA policy that patients must be assigned to a treating specialty code of observation, as applicable, and that all services and costs associated with observation treating specialties are to be captured and assigned to inpatient services.

**4. ACTION:** The facility Director is responsible for ensuring that:

a. The following patient treatment file (PTF) treating specialties and cost distribution report (CDR) account numbers are utilized for recording observation patient activity.

**THIS VHA DIRECTIVE EXPIRES SEPTEMBER 30, 2008**

| **Treating Specialty** | **PTF #** | **CDR #** |
|---|---|---|
| Medical Observation | 24 | 1110.00 |
| Surgical Observation | 65 | 1210.00 |
| Psychiatric Observation | 94 | 1310.00 |
| Neurology Observation | 18 | 1111.00 |
| Blind Rehabilitation Observation | 36 | 1115.00 |
| Spinal Cord Injury Observation | 23 | 1116.00 |
| Rehabilitation Medicine Observation | 41 | 1113.00 |

b. These treating specialties are utilized when setting up observation units. Use the following guidelines and menu options for assistance. Using the ward definition menu option, create observation unit wards.

(1) The treating specialty needs to be one of the preceding observation treating specialties appropriate for the ward location. The service for the observation unit ward should be NON-COUNT. Remember to include the Gain and Losses Sheet (G&L) location. Using the treating specialty set-up option, set up the new treating specialties.

(2) Patients placed on observation status are to be admitted to one of the preceding listed treating specialties (see subpar 4a). This enables the facility to track the patients on the G&L. An observation patient requiring subsequent admission would be released from observation status by discharging them from the facility and then admitting them to an acute care-treating specialty.

(3) Patients already designated as inpatient status must be discharged and re-admitted to an observation treating specialty for no more than 23 hours (especially normal ambulatory surgery which are not related to the reason for hospitalization). Following the observation period, the patient must be re-admitted to inpatient status if further hospitalization is required. Nursing Home Care Unit (NHCU) and Domiciliary (DOM) patients requiring observation services are to be transferred Absent Sick in Hospital (ASIH) from the NHCU or DOM and admitted to an observation treating specialty. A principal diagnosis needs to be available for these patients at the time the patient is either discharged and re-admitted to another treating specialty for inpatient care or to an appropriate ambulatory care setting.

***NOTE:*** *Utilizing this data report methodology enables data users to separate the activity of these patients for their purposes. For performance measurement purposes, these patients would NOT be included as acute care inpatients. Procedures performed while a patient is assigned to observation status will be considered ambulatory for performance measure purposes.*

c. Documentation is accurate and complete.

(1) PTF records for reporting observation patients when discharged from observation status are completed and transmitted. If a patient is admitted following observation, the acute care PTF record is to be transmitted after discharge from inpatient care.

(2) Attachment A outlines the minimal requirements for patient record documentation of observation patients. Again, the goal of observation is to resolve symptoms or clarify a patient's diagnosis; this needs to be clearly stated so clinical care is focused and the record can be coded appropriately.

d. Billing is accurate and processed in a timely manner.

(1) Insurance carriers of patients on Observation status are to be billed at the appropriate inpatient rate for the bed section providing the care using revenue code 760, until such time as an observation unit rate can be established. This is a facility charge and needs to be billed on a Uniform Billing Form (UB)-92. For billing professional fees, Current Procedural Terminology (CPT) codes are to be used.

(2) First party patient co-payments for observation patients are to be billed as outpatient co-payments according to the Decision Support System (DSS) stop indicator for the observation service provided.

**5. REFERENCES:** None.

**6. FOLLOW-UP RESPONSIBILITY:** The Office of Information (19F) is responsible for the contents of this VHA Directive. For issues and questions affecting classification of patients, contact the Chief Business Office (16), at (202) 254-0327. For issues concerning billing, contact the Chief Business Office (16), at (202) 254-0320.

**7. RESCISSIONS:** VHA Directive 98-025 is rescinded. This VHA Directive expires September 30, 2008.

S/ Nevin M. Weaver for
Robert H. Roswell, M.D.
Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 10/1/2003
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 10/1/2003

**ATTACHMENT A**

## OBSERVATION PATIENT RECORD DOCUMENTATION REQUIREMENTS

| DOCUMENT OR ITEM | COMPLETION TIME | COMPONENTS OF DOCUMENT REQUIRED |
|---|---|---|
| Admission Order | On Admission | Timed and dated order for admission of the patient to an Observation Bed. |
| Initial Assessment and History and Physical (H&P) | Immediately | Initial Assessment and screening of physical, psychological (mental) and social status to determine the reason why the patient is being admitted to an Observation Bed, the type of care or treatment to be provided, and the need for further assessment. An extensive Emergency Room (ER) note or Progress Note, documented by the admitting physician, which encompasses the normal criteria for an H&P will suffice as an initial assessment and H&P for the Observation patient. |
| Progress Notes | Within 8 hours - with subsequent notes documented as the patient's condition warrants. | Progress Notes should reflect the status of the patient's condition, the course of treatment, the patient's response to treatment, and any other significant findings apparent at the time the progress note is documented. Reassessments should include a plan for (1) discharge or transfer; (2) admission or readmission to inpatient status; or (3) continued observation with evaluation and rationale. |
| Discharge Order | On Discharge | Timed and dated order for discharge from the Observation status. |
| Discharge Diagnoses | On Discharge | Complete listing of all final diagnoses including complications and comorbidities. |
| Discharge Note | On Discharge | Summarization of the reason for the Observation admission, the outcome, follow-up plans and patient disposition, and discharge instructions (diet, activity, medications, special instructions). ***NOTE:*** *This document may be written in the Progress Notes or dictated, according to local policy.* |